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CONTENTS.

CLINICAL LECTURES.

On Dyspareunia. By T. Gaillard Thomas, M.D., Professor of Obstetrics and the Diseases of Women and Children in the College of Physicians and Surgeons, New York 17
On Horsehair as a Drain for Wounds . 22

HOSPITAL NOTES AND GLEANINGS.

Cases of Stricture of the Pylorus treated by withholding Food 25
A New Operation for Fracture of the Patella 26

MEDICAL NEWS.

Domestic Intelligence—Rectal Alimentation 26
Report of the Surgeon General . . . 26
The Boston Medical and Surgical Journal 27
Personal 27
Obituary Record 27
Foreign Intelligence—Mr. Spencer Wells and the Samaritan Hospital . . . 27
Salicylic Acid 28
Antiseptic Surgery 28
Iodoform in Fissure of Anus . . . 29
Relation between Urinary Secretion and Irritation of Spermatic Plexuses . . 29
Pneumonomycosis Sarcinica . . . 29
Atmospheric Germs 29
Death from Chloroform 30
Handy Antidotes 30
Iodized Cod-Liver Oil 31
Health of Grocers and Drapers . . . 31
Poisonous Wall-papers 31
Obituary Record 31

GOSSELIN'S CLINICAL LECTURES ON SURGERY . . . . 16 PAGES.

CLINICAL LECTURES.

ON DYSPAREUNIA.

By T. GAILLARD THOMAS, M.D.,
Professor of Obstetrics and the Diseases of Women and Children in the College of Physicians and Surgeons, New York.

(Reported by P. Brynberg Porter, M.D.)

GENTLEMEN: The case which I bring before you to-day is one of considerable interest in several respects; but there is one special feature about it upon which I should like to dwell at some length a little further on. The patient's name is Mrs. Rose G., aged thirty-eight years. She is a native of Ireland, has been married fourteen years, and has had five children and one miscarriage. Her youngest child is two years old, and the miscarriage, which was at the third month, occurred two months ago. Though never very robust, she tells us that the trouble of which she now complains has been experienced only since July last (four months). She suffers continually from a fixed pain seated in the right iliac fossa, and not infrequently extending down the lower extremity of that side as far as the toes, and chiefly affecting the great toe. It always runs down the anterior and inner aspect of the limb, and never the posterior part as well. At the time of the menstrual periods this pain becomes very greatly increased, and extends around to the back, which is never the case at any other time. At the last two menstrual

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epochs it has been so severe as to confine her to bed, and cause her the most intense suffering. It becomes severe, she says, about two days before the catamenia make their appearance; but when the flow begins, it again diminishes. From the history to which you have just listened, my suspicions were at once excited in regard to one organ, and that was the right ovary. But why not the uterus or left ovary? Because of the seat and peculiar character of the pain, which, you will remember, is fixed at all times in the right iliac fossa, is excessively aggravated and extends around to the back, at the menstrual epochs (and at this time only), by reflex action runs down the inner side of the leg to the great toe, becomes increased two days before the appearance of the menstrual flow, and, lastly, is relieved when the flow begins. These are the peculiarities of ovarian pain, and whenever they are noticed you should always suspect one, or perhaps both, of these organs. Putting a few direct questions to the patient, we find that she suffers constantly from leucorrhœa, but has no irritability of the bladder or rectum; and that the pain of which she complains has been much worse during the last two months (or, in other words, since her miscarriage) than it was before.

In the physical examination, with the patient lying on her back, the first thing that I noticed when I passed my finger into the vagina was, that the os uteri was not in its normal position, but considerably higher up than it ought to have been; and I also found that the cervix was lacerated to a certain extent. Carrying the finger back of the cervix, I felt a soft mass apparently connected with it, which I suspected to be the body of the uterus; and on conjoined manipulation, which was made without any difficulty, after a few forced expirations, on account of the laxness of the abdominal walls, I ascertained with certainty that the uterus was enlarged, retroverted, and tender on pressure. But this was not all that I discovered; for, upon pressing over the right broad ligament with the hand that was upon the abdomen, I detected a pulpy mass of the size of an English walnut lying back of the uterus in Douglas's cul-de-sac, and so exquisitely sensitive that the patient cried out with pain the moment that I touched it. Now I was fully prepared to find such a body in this position, and would have been much disappointed if I had not, because the history pointed so evidently to chronic ovaritis of the right side. It might, perhaps, be supposed that the body which I felt was either a fibroid or a small phlegmon; but fibroids are not sensitive, and cannot be pushed away from the uterus, as I found it possible to do with this mass, and though phlegmons are tender on pressure, its mobility also showed that it could not be one of these. Furthermore, the great nervousness of the patient was an additional reason for supposing it to be an ovary.

The patient was now placed upon the side, and a Sims speculum introduced, when the ovary was pushed completely up out of reach. In order to confirm the diagnosis of retroversion, the uterine probe was passed to the fundus (which did not occasion the patient the slightest inconvenience), and it was found to take a downward and backward direction. Here, then, was a case of laceration of the cervix, hyperplasia, and retroversion of the uterus (the latter being probably caused by the former), and of chronic ovaritis. The patient is at a loss to account for the miscarriage from which she suffered two months ago, but it was no doubt due to one or more of the above abnormal conditions.

But there is one other symptom of the case of which I have not as yet spoken, but which is a very prominent one, and one to which I now desire to call your particular attention, and that is *dyspareunia*. I have already had occasion to allude to it in connection with the first case presented to you at the clinic this session; but to-day I propose to examine a little more fully into its causes and treatment. I accept the term, which means difficult or painful coitus, from Dr. Barnes. It is derived from the Greek word δυσπάρευνος,[1] signifying *ill-mated*. The only

[1] This is composed of the words δυς and παρευνες, the latter being made up of παρα and ευνη (the marriage bed).

way to treat this symptom is to find out all that you possibly can about the cause, and then remove that if it is practicable. Now how shall we approach it in the case before us? When the finger is passed into the vagina, three tender points are detected by it. The first met with is the cervix, at the part where it has been lacerated, for this accident has produced a neuralgic condition here. The second is the congested and displaced uterus, and this may, perhaps, have something to do with its causation; but neither of these conditions, as I would have you particularly note, is often concerned in the production of dyspareunia. Thirdly, we have an inflamed and exquisitely sensitive ovary, and that, you will find, is one of the commonest of its causes. The pain on pressure, too, is far more acute than at either of the other points just spoken of. You remember the aphorism of Hippocrates, *Propter uterum mulier est;* Prof. Peaslee in his work has rendered it more strictly correct by substituting the word *ovaria* for *uterum*. The ovary may be not inappropriately termed the pendulum of the female clock; and I have not the slightest doubt that this woman could be easily thrown into an hysterical condition by a little continued pressure on the diseased organ.

These cases of dyspareunia are often exceedingly troublesome, and they will tax your ingenuity to the utmost when you get into practice. It is a most prolific cause of domestic infelicity, for the husband is made unhappy, and the wife is not only rendered mentally miserable, but suffers from the most profound derangement of her nervous system. The causes of dyspareunia are numerous, but I will endeavour to enumerate all that you will be at all likely to meet with. You will be pretty certain to find one or more of these conditions present in every case of the affection in which you are consulted, and if you will bear them in mind, you will be surprised to see how often you can remedy the trouble, and how much real happiness you will thus have the means of conferring. You all know how much a man is physically disordered when he is unhappy; a woman's disorder is always tenfold greater from the same cause. The first cause that I will mention is—

Hyperæsthesia of the Hymen and Ostium Vaginæ.—If you will recall the case of vaginismus which I showed you about a month ago, and the extreme suffering which the mere attempt to introduce the finger within the vulva occasioned the patient, you can readily appreciate why this should be a very prominent cause of dyspareunia. But it sometimes happens that after this condition has been removed, the symptom still persists, because there has been some other cause present as well.

(2) *Diseased conditions of the Os and Cervix Uteri.*—Lacerations sometimes produce it, as we have seen, and it is also occasioned by hyperplasia of the cervix resulting from chronic inflammation of its lining membrane, which affects the nerves supplying the parenchyma.

(3) *Stricture of the Vagina.*—This is sometimes congenital and sometimes the result of the exanthemata or of continued fevers, like typhoid and typhus, occurring during childhood. I have seen one case in which it followed measles. Sloughing of the vagina was a concomitant or sequel of the disease, and a stricture was its result. Such strictures often escape notice entirely until after marriage, for they do not amount to complete atresia of the vagina; but while they permit a free passage of the menstrual blood they present an effectual barrier to sexual intercourse.

(4) *Pelvic Cellulitis and Peritonitis.*—These are two of the most irremediable causes that you will meet with. As a result of the inflammatory process, the whole pelvic roof becomes, as Dougherty expresses it, as hard as a deal board, and often extremely sensitive to the slightest pressure upon it.

(5) *Uterine Displacements.*—The dislocated organ is in a neuralgic condition, because there is marked derangement of its innervation and circulation. Unlike the last, this condition is one of the most curable of the causes of dyspareunia.

(6) *Coccyodynia.*—The attention of the profession was first prominently directed to this affection by Sir James Y. Simpson,

but it was really observed before this by the late Dr. Nott of this city. There are two forms of it, one purely neuralgic in character, and the other an actual disease of the bone (caries), and the latter is much the more severe. There is sometimes a most violent pain during defecation from it, and sometimes a continued neuralgic condition of the coccygeal nerves.

(7) *Fissure of the Anus*, and

(8) *Irritable Urethral Caruncle.*—The latter is a little proliferation of the structures of the mucous membrane at the meatus urinarius, usually about the size of a small strawberry, and having loops of nerves running down into it, which render it excessively painful during micturition and coition.

(9) *Chronic Cystitis.*—This is quite a common affection among females, though it is, perhaps, a somewhat rare cause of dyspareunia. But sometimes the inflamed viscus is acutely sensitive, and the irritability which characterizes it is communicated to the adjacent parts.

(10) *Short Vagina.*—This is another cause which is congenital, and which remains unaltered through life. The uterus remains in a constant state of irritation from coitus (which occasions the patient very great suffering), and continually pours forth a glairy discharge of mucus. The greatest unhappiness to both man and wife frequently results, and to illustrate this I will relate a case which came under my notice some time ago. The husband was a vigorous man of powerful physique, and, though very wealthy, of not much refinement. His wife, unfortunately, suffered from the trouble which we are now discussing, and in consequence he became exceedingly morose, and at length left her altogether. He then got into bad habits, and about a year ago committed suicide; this melancholy result being attributable, as I believe, to the condition spoken of. Of course, I may be mistaken in my explanation of the case, but from the circumstances I can hardly doubt that it is the true one. Before leaving it, I may say that, owing to the constant discharge from the cervix, the patient was never pregnant.

(11) *Disproportion.*—As we read in the Scriptures that "there were giants in those days," so there are now. To no class of cases can the original signification of the word dyspareunia, "ill-mated," be more appropriately applied. This is one of the causes which, as you may readily imagine, is the most irremediable, and this unfortunate abnormal development on the part of the male often occasions the greatest amount of distress. Lastly, we come to the cause which is no doubt the true one in the case before us, and which I have left to the last not because it is an unimportant one, but simply for the reason that it exists in our patient, viz.:—

(12) *Chronic Ovaritis.*

There are two other conditions which occasionally produce dyspareunia, but I would not rank them with those already given, because when present they are accompanied by other symptoms which are much more prominent than this. They are—

(13) *Malignant Disease of the Cerviz.*—And—

(14) *Fibroids situated near the Cerviz.*—These are ordinarily not at all sensitive; but if they take on an inflammatory process, as is occasionally the case, they become so.

I now propose to speak of the removal of some of these causes. The first step towards this in any given case is, of course, to ascertain what is the true cause of the dyspareunia. Have we done so in the present instance? I think so, but am not positively sure in regard to it. I think it probable that if the inflamed ovary could be kept up in its proper position in the pelvis, where it would be out of reach of the irritation produced by coitus, and its present diseased condition be somewhat ameliorated, the dyspareunia would entirely disappear. But, as we have seen, there are other conditions present here which may possibly give rise to the symptom. How shall we then decide? Well, we may regard the matter as pretty certainly determined by the fact that the ovary presents the point of maximum tenderness, the sensitiveness of the other two points before mentioned

being insignificant compared with it. If the first cause upon the list, viz., hyperæsthesia of the hymen and ostium vaginæ, were present, the mere attempt to separate the labia would occasion the patient an extreme amount of suffering, and produce a high state of nervous excitement. I have so recently spoken of the treatment in this condition that it will be unnecessary for me to go into the subject now. If there is some diseased condition of the cervix, like the laceration in the present case, a careful digital and specular examination will reveal all that is requisite to enable us to relieve it. If there is a stricture of the vagina, or an abnormally short vagina, the mere passage of the finger will be sufficient to detect the condition, though unless the greatest care is observed we may be deceived as to the fact of a vagina being really too short. If dyspareunia is the result of pelvic cellulitis and peritonitis, we would find great tenderness existing all over the hypogastrium, when conjoined manipulation is attempted, and about the roof of the pelvis. We may also find hard masses of exudation or collections of pus, which have resulted from the inflammatory affection.

Some of the other conditions mentioned must be looked for very carefully, or we shall fail to discover them. It is astonishing how frequently patients, in describing their symptoms, will entirely omit to mention the most important of all. A woman, for instance, will come to you with a vague account of some dyspeptic derangement, and never say a word about the pint of blood which she may have vomited a day or two previously. I once knew of a sailor on a man-of-war who, while under treatment for fracture of the thigh by the young assistant surgeon of the ship, was visited by the fleet-surgeon in his rounds, and described to him a long train of symptoms, but neglected altogether to mention the broken leg. Intense agony during defecation is the most prominent symptom of fissure of the anus, and yet those who suffer from it will sometimes not mention it, because females, as a rule, dislike very much to speak of this condition. You know how much suffering a little crack at the corner of the mouth will occasion in cold weather, giving rise to some neuralgic pain which extends as far up as the eye. The pain from fissure of the anus is of the same character, but infinitely more intense, and during the act of coition affects the nerves of all the surrounding tissues. Pain is thus transmitted all over the vagina, and the same is true in regard to coccyodynia. We must be very careful not to overlook a sensitive urethral caruncle. It is apt to give rise to great irritability of the bladder; but irritability of this viscus is so frequent an occurrence in females that they seem sometimes to regard it as really a natural condition, and will not remember to mention it. So chronic cystitis not infrequently entirely escapes notice, and though it is often a very intractable affection, it is frequently amenable to treatment by means of free dilatation of the urethra, which enables us to keep the bladder thoroughly washed out by the use of appropriate injections. As I have previously indicated, nothing can be done where there is a congenitally short vagina, or when disproportion is found to exist.

But chronic ovaritis especially concerns us to-day, and I am confident that we can do a great deal of good in the way of treatment in this particular instance. We shall utterly fail in all our attempts to give relief here, however, unless we can raise the ovary out of its present position and keep it so elevated. It was demonstrated that it could easily be forced up out of Douglas's cul-de-sac when the speculum was introduced, and I would now recommend that it should be retained in its natural situation by some appropriate form of pessary. The shape and size of the vagina vary so greatly in different individuals, that in any case whatever in which a pessary is to be worn, it is absolutely essential that only one especially adapted to it in every way should be inserted. There is too much indiscriminate use of pessaries at the present day, and this I believe to be one great reason why they so often do harm, and why they have gotten into such bad repute in certain quarters. In the present instance I might,

perhaps, at first make use of the simple elastic rubber ring, known as Meigs's pessary; and finding that this did not accomplish the result designed, I might employ Hodge's or Albert Smith's modification of that; or, more probably, I might resort to a modification of Cutter's very excellent pessary, which is retained in position by an elastic band attached to an abdominal belt, and whose essential feature is a hard-rubber bulb which fills up all the post-uterine space, and would thus effectually keep the ovary up out of Douglas's cul-de-sac.

Further than this, the patient should be instructed to remain very quiet at the time when physiological congestion of the ovary occurs. For several days before each menstrual period she should lie in bed, while the bowels should be kept relaxed and every possible source of irritation removed. When the flow makes its appearance she should be allowed to get up again, for she is to be treated not for disordered menstruation but disordered ovulation. There is one remedy which seems often to have a favorable influence in these cases by allaying nervous excitability, and that is bromide of ammonium. I am in the habit of giving it in from ten to fifteen-grain doses, combined with some bitter tonic, three times a day for four or five days at the menstrual epoch; always taking care to antedate somewhat the period of ovulation.

Lastly, galvanism should be given an extended trial here; the constant current ought always to be used in such cases. I would recommend that about twice a week one sponge electrode, mounted on a long handle, should be applied directly to the ovary, or as near to it as you can get in the vagina; and that the other, a broad, flat one, should be applied successively for a few minutes to the abdomen, and the spine, near the dorsal vertebræ. I have been told by specialists in electro-therapeutics, that this is a very uncertain method of reaching the ovary with the galvanic current; but as they have been unable to suggest any better way, I still continue to employ it.

On Horsehair as a Drain for Wounds — Prof. LISTER, in the course of a clinical lecture on a case of excision of the knee-joint (*Lancet*, Jan. 5, 1878), called special attention to the manner in which drainage was provided. He said: Next to the importance of the avoidance of putrefaction in wounds is the prevention of tension by providing a free escape for effused blood and serum. This we have hitherto generally done by means of the caoutchouc drainage-tube of Chassaignac. But in the present case such a tube would have been unsuitable, because the natural position for the drain was that it should run between the ends of the bones which, as we have seen, were pressed together, so that the calibre of a caoutchouc tube would have been altogether obliterated, and the drain in a most important part of its course rendered useless. Under these circumstances I used a drain of horsehair, because such a drain operates by capillary attraction through the interstices between the hairs, and those interstices cannot be obliterated by pressure, seeing that the hairs are not individually compressible.

The drain was introduced in a manner which you will often find useful. It may frequently happen that the most dependent part of a wound may have no opening in the skin to correspond with it; thus after excision of the mamma it may turn out, when the operation is concluded, that the wound presents a pocket extending considerably further back than the outer angle of your incision. Under such circumstances it is desirable to make an opening for the exit of the drain at the most dependent part. Now, if this were done by a puncture with the knife, some arterial branch of considerable size might be wounded, involving the necessity of freely enlarging the wound to secure the bleeding point. But if you take a pair of dressing forceps, and bore steadily from within outwards, the conical extremity of the instrument will slip past any arterial branch or nervous trunk without injuring it, and when at length it is apparent that there is nothing

but skin between the instrument and the surface, the tough integument is divided with a knife over the point of the forceps, and the blades being forcibly expanded so as to enlarge somewhat by laceration the opening which has been made in the muscles, or other deeper textures, the drain is seized between the blades of the forceps, and drawn into place. So in the present case the most eligible position for a dependent opening was at the outer aspect of the limb, where the use of a knife would have involved the risk of injuring the external popliteal nerve, or of dividing some articular arterial branch. Any such difficulty was avoided by employing the dressing forceps in the manner described.

It is only right that I should mention, when alluding to the horsehair drain, that its use did not originate with myself. We were led to its adoption in the following manner: Mr. Chiene, of Edinburgh, suggested some time ago the employment of catgut as a substitute for the caoutchouc tube. He hoped by this means to provide adequate drainage through capillary attraction, and at the same time, by virtue of the proneness of the catgut to absorption, to do away with the necessity for the withdrawal of the drain from time to time, which there is when the caoutchouc tube is used, whether for the purpose of shortening the tube or substituting a small one for a large. Mr. Chiene's anticipations were to a considerable extent realized. In all cases in which the wound remained aseptic the absorption of the deeper part of the catgut drain, and consequent falling off of the part outside the wound, might be reckoned on as a matter of course; and in several cases in which the catgut was so used, both by Mr. Chiene and afterwards by myself, the drainage proved adequate and satisfactory. Mr. White, of the Nottingham General Infirmary, afterwards substituted horsehair for catgut; not because it was supposed to be superior, but because, whereas the prepared catgut is a somewhat expensive article, a horse's tail is a very cheap one. A notice of this use of horsehair was published by Mr. White's house-surgeon, Dr. L. W. Marshall, in *The Lancet* of Dec. 2d, 1876; and in the following month it was employed by myself, in the Edinburgh Royal Infirmary, in a case of chronic bursitis of the sheaths of the flexor tendons at the wrist, in which it seemed likely to be peculiarly serviceable. In this affection the bursa is distended both above the wrist and in the palm, the cavities thus constituted being connected by a constricted passage under the annular ligament; and it is desirable that both the expanded parts should be opened to give exit to the fibrinous concretions which are generally present (varying in size from that of a millet-seed to that of a small bean), and, further, that drainage should be provided for effused serum, the operation being performed antiseptically, in order to avoid the very serious inflammatory disturbance and suppuration which are otherwise apt to occur. I had previously used the caoutchouc tube as a drain in such a case, but I found a difficulty from the liability of the tube to be compressed by the tendons. This might, I thought, be overcome by the use of the horsehair drain, which at the same time would, for this particular purpose, be superior to one of catgut, because the catgut would probably be absorbed before the necessity for drainage would be over. Accordingly I cut down above the wrist, making my way between the tendons of the flexor sublimis to the distended sheath of the flexor profundis, and, as soon as this was opened, passed in a large bullet-probe, somewhat curved, slipped it along under the annular ligament, and pressed it forcibly towards the palm, so as to perforate the palmar fascia while avoiding injury to the palmar arch, and, having divided the skin over the point of the probe, dilated the opening in the fascia with dressing forceps, and then passed into the eye of the probe a substantial drain of horsehair, which had been well purified by steeping in a 1 to 20 solution of carbolic acid, and withdrew the probe, leaving the horsehair drain in its track. The drain answered admirably, and presented the further great advantage that it could be reduced in bulk in accordance with

the diminution of the serous discharge, by drawing out as many hairs as might be desired; and in the course of three weeks, the last portions of the drain having been withdrawn, the wound healed without the occurrence of suppuration from first to last.

While the horsehair has the advantage over the catgut that it can be used when necessary over a longer period, it has, in some cases, the converse superiority that it can be not only reduced in bulk, but withdrawn altogether at an earlier period than is required for the absorption of the catgut; for the catgut, in process of organization and absorption, becomes more or less incorporated with surrounding tissues through the medium of the cells of new formation which invade it, and, if an attempt is made to withdraw the drain in whole or in part, there will often occur inconvenient oozing of blood through the rupture of newly formed vessels. And if, on the other hand, the drain is left intact till the parts of the catgut within the wound are entirely absorbed, there remains a small granulating sore at the place of exit of the drain, which may retard for some days the complete healing of the wound. Further, the threads of the catgut, as they undergo organization, are increased in bulk by the formation of the new cells, and their interstices are liable to be more or less choked, so as to interfere with effective drainage. The horsehairs, on the other hand, lie unchanged among the tissues, and their interstices remain to the last as effective as they were at the outset.

The next case in which I used the horsehair drain was one which you yourselves witnessed—viz., that of transverse fracture of the patella, treated by laying open the joint, drilling the fragments obliquely, and tying them together by means of strong silver wire. Being apprehensive that blood and serum might be effused into the joint to such a degree as to produce inconvenient tension unless a free exit was provided, I resolved to introduce a drain at a dependent part of the articular cavity; but I feared that, if a caoutchouc tube was used, it might be rendered inefficient by being compressed between the condyle of the femur and the neighbouring tissues. I therefore had recourse to the horsehair, introducing into the posterior and outer part of the joint a drain, about a quarter of an inch in thickness, by means of the dressing forceps employed as before described. It worked to admiration; for, though there was, indeed, in the first twenty-four hours, a very copious sanguineo-serous effusion, as shown by the soaking of the antiseptic gauze, yet not the slightest swelling of the joint occurred, and, after nine days, the small remains of the drain, which had been previously reduced at successive periods, were withdrawn, to allow the puncture to close. The drain of horsehair was as pure and white[1] as if it had been merely dipped in water; having been washed quite clean of the blood which first occupied its interstices by the colourless serum which, after the cessation of the original sanguineous effusion, had been the only discharge. I was so much impressed with the satisfactory working of the horsehair drain in that case that we have since employed it in preference to the caoutchouc tube in all our wounds, and have had good reason to be pleased with the change. (If it be necessary to reintroduce a horsehair drain, it is readily done by taking a wisp of hair of half the thickness required, bending it in the middle at a sharp angle over a probe, and tying a piece of carbolized silk round it close to the probe, on withdrawal of which the drain is left with a rounded end which passes readily into the interior of the wound.)

In the case of this little girl the horsehair drain has worked perfectly well in spite of the pressure to which it was subjected. The flow of blood and serum was, in the first twenty-four hours, extremely free, but there was no appear-

[1] I used white horsehair in this case simply because I did not happen to have at hand any of the black, which is generally preferable, because the individual hairs are thicker, while the dark colour has the advantage of making them more conspicuous, especially when they are used for sutures.

ance of the retention of any of it within the wound. On the occasion of the last dressing, two days ago, more than half of the drain was removed. That dressing took place after an interval of three days, and it would be superfluous to change the dressing to-day, were it not that we may, perhaps, be justified, by the further diminution of the discharge, in withdrawing the remainder of the drain entirely so as to permit its track to close.

HOSPITAL NOTES AND GLEANINGS.

Cases of Stricture of the Pylorus treated by withholding Food.—A dock-labourer, aged 41, was admitted to the London Hospital, under the care of Dr. SUTTON, complaining of inability to take solid food, as it always produced great distress; he also complained of heartburn and frequent vomiting. Upon inquiry, it appeared that he had suffered at intervals from severe dyspeptic symptoms during two years, the attacks having become more severe and more frequent of late, so that he was at last unable to take meat or solid food of any kind. He had also often been much distressed by a feeling of tightness across the abdomen, increased by food and relieved only by vomiting, so that he frequently put his finger to the back of his mouth to cause regurgitation. His habits were temperate. Dr. Sutton remarked that the order of symptoms was not indicative of chronic ulcer or of gastric catarrh. The sensation of tightness in the abdomen, the oozing of mucus, and frequent sour rising into the mouth, rather pointed to incipient stricture of the pylorus; and the constant vomiting strengthened that idea, although no distinct thickening could be felt through the abdominal walls. The emaciation might be attributed to the constant vomiting and inability to take food.

While under observation, he frequently vomited yeast-like acid matter containing sarcinæ, which, when kept, rapidly underwent fermentation; he was much troubled by flatulence and headache. Food was given in small quantities, consisting of mince-meat, with very little bread and eggs beaten up with milk arrowroot. The stomach was washed out every day with warm water by means of the œsophageal tube. Under this method of treatment and rest in bed, he improved much in general condition; the vomited matter became less fermentable, and the sarcinæ disappeared.

Relapses, however, occurred, and, at two periods of the treatment, he was fed for three days by nutrient enemata only, no food being taken by the mouth, except a little brandy and water. This plan did not greatly try the patient, and produced a marked relief of the symptoms. The man was under treatment for three months; during that time he improved much in general appearance, and gained seven pounds in weight.

The second case was that of a man aged 55, who, on admission, complained of "windy spasms" and inability to keep down food. He was a blacksmith, and, during adult life, had enjoyed good health, but his habits had not been temperate. He said that, for four or five years before coming to the hospital, he had suffered from distension after food, otherwise his health had not failed till the last three or four months, when vomiting of food became frequent and troublesome. Food caused distress, which was relieved only by vomiting. Formerly, he had been stout, but lately he had become emaciated, and his weight reduced from ten stones to seven stones and a half; his appetite had continued good, but he was afraid to eat. There was neither cough, heartburn, nor jaundice, and, on physical examination, the stomach appeared enlarged, and a distinct thickening was felt in the neighbourhood of the pylorus. It appeared probable that the man was suffering from a slowly growing scirrhous infiltration of the pylorus, causing stricture. Other treatment failing to arrest the vomiting, he was ordered to take no food by the mouth for three days, except a little brandy, and was fed by nutrient enemata. Great relief of the symptoms was thus afforded; the vomiting and feeling of distress subsided, and he was again able to take light food, while the stomach was washed out daily.

He was thus kept in comparative com-

fort, though the disease slowly advanced, and he died three months after his admission to the hospital.—*Brit. Med. Journ.*, Dec. 8, 1877.

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A New Operation for Fracture of the Patella.—In a case of fracture of the patella treated at King's College Hospital, Mr. LISTER cut down on the fragment, opening the knee-joint, cleansed the surfaces of the fragments, and, having established an independent drain of horsehair for the knee-joint, drilled the two portions of the patella and tied the fragments together with silver wire, and then closed the wound, which was also also drained with horsehair.

This operation was performed six weeks ago; the wound, as exposed to-day, was seen to be completely healed, the ends of the silver wire projecting through the scar. The highest temperature that had occurred was 100 deg. Fahr. on the morning after the operation. There has been no disturbance, constitutional or local, and both the wounds healed in about a fortnight.

The limb will be kept at rest for another fortnight, when, if union have taken place, the wires will be withdrawn.—*Brit. Med. Journ.*, Dec. 15, 1877.

MEDICAL NEWS.

DOMESTIC INTELIGENCE.

Rectal Alimentation.—In some recent remarks on this subject (*Med. Record*, Jan. 19, 1878), Dr. AUSTIN FLINT recommends a variety of diet rather than the persistent use of the same kind of food prepared in precisely the same way. The articles now used were meat solution, pancreatic emulsion, Liebig's extract of meat with or without milk, milk, eggs, mutton and chicken broths. A pancreatic meat emulsion was mentioned, made as follows: From five to ten ounces of finely chopped meat were added to fully one-third of that weight of the fresh pancreas of the ox, the fat being removed, and mixed with about five ounces of water; the whole was reduced to the consistence of a thick soup.

In cases in which the rectum was or became irritable, one-half of a pint of milk could be carried up into the colon and be retained without difficulty. The average quantity of material to be employed in this mode of treatment was from three to six ounces, and the intervals between the injections might vary in length from three to six hours. Small quantities of some preparation of opium might be added to the injection, if they were not well tolerated. It remained to be settled whether or not opium had the same influence upon rectal as upon gastric digestion—namely, to impair it. Preparatory to the beginning of the treatment, the bowels should be emptied either by means of enemata, or by a laxative given by the mouth. As a substitute for drink, when necessary, simple water may be thrown into the bowel, and the surface of the body freely sponged.

At first nutritive injections might not be retained; but, if persisted in, they would soon be well tolerated. On the other hand, in some cases they were well tolerated at first, but after a time they were not retained. In such cases it was well to stop them for a short time, when they could probably be renewed with success. It was not thought necessary to wash out the rectum each time prior to using the administration of the nutritive injection. The nutritive injection should be *tepid*. Firm pressure should be made over the anus with a sponge or towel, until the desire to remove the injection had passed away. If the nutritive injections met the requirements of the case, there would follow a sense of comfort and satisfaction the same as after taking a meal in the ordinary way.

With reference to irritability of the rectum such as prevented retention of the nutritive injection, even though opium was added, Dr. FORDYCE BARKER had overcome that difficulty by passing the tube high up into the colon, so that the fluid would be thrown into the intestine *above* the rectum.

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Report of the Surgeon General.—The annual report of the Surgeon General of the Army has been published, and the profession will be pleased to learn that

the work of cataloguing the original papers in medical journals and transactions has been completed to date for all this class of literature which the library has been able to obtain; and the classifying these titles under the proper subject headings, and combining them with titles of works, in order to form a complete index to the collection, has been effected to a great extent. Of the value of this work there can be no question, and we hope that every physician will use his influence with Members of Congress to procure the authority for the printing of this catalogue by the Government Printer, which has been asked for.

The second volume of the Medical History of the War of the Rebellion it is expected will be ready for issue by June of this year.

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The Boston Medical and Surgical Journal.—The retirement of Dr. Thomas Dwight from the editorial management of the *Boston Medical and Surgical Journal*, in which he has been associated for the past five years with Dr. J. Collins Warren, is announced. Our Boston contemporary thus speaks of the services he has rendered to it: "The many changes which the Journal has undergone during this, a not uneventful, period in its history, and the favorable results which have followed therefrom, are in no small degree due to his able management and his courageous stand in delicate questions involving professional interests or public welfare, where his power for satire or praise and his ability in argument have forcibly displayed themselves, and have contributed to the increased influence exerted by the Journal upon the community as well as the profession in which it circulates."

In the retirement of Dr. Dwight, medical journalism has lost a valuable coadjutor, and our contemporary an editor whose able pen undoubtedly did much to win for it the high esteem with which it is justly regarded.

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Personal.—Dr. W. R. Whitehead, formerly of New York and recently of Colorado, has removed to Paris, where he is now practising at No. 14 Rue d'Alger.

Obituary Record.—At New York, on the 21st of January, aged sixty-four, Edmund Randolph Peaslee, M. D., LL.D., Professor of Gynæcology in Bellevue Hospital Medical College, President of the American Gynæcological Society, and Surgeon to the New York State Woman's Hospital.

Dr. Peaslee was born at Newton, N. H., in 1814, and graduated in the arts at Dartmouth College in 1836. He took his degree in medicine at Yale in 1840. From that time to the present he has been actively engaged in medical teaching. In addition to his contributions to the pages of the *American Journal of the Medical Sciences*, Dr. Peaslee, in 1857, published a work on Human Histology, and in 1872 an elaborate treatise on Ovarian Tumours and Ovariotomy, which will long remain an authority on the subject of which it treats. Dr. Peaslee was greatly respected for his professional skill, and held in high esteem for his personal worth. He was elected, in 1871, President of the New York Academy of Medicine. He was formerly Professor of Anatomy in the New York Medical College, and Professor of the Diseases of Women in Albany Medical College.

Dr. Peaslee died of pneumonia after a few days' illness.

FOREIGN INTELLIGENCE.

Mr. Spencer Wells and the Samaritan Hospital.—On Dec. 12th Mr. Spencer Wells performed ovariotomy for the 404th time at the Samaritan Hospital. After the operation, he remarked that it was twenty years since he first joined the institution, which was then a dispensary. His first ovariotomy in connection with the institution was done about twenty years ago, and fortunately the first three cases recovered. Had they proved fatal the history of ovariotomy would probably have been different, and the operation might have remained under a cloud. The mortality in each quinquennial period had steadily diminished; it being one in three during the first five years, one in four in the next five, and one in five in the third five years. Still more recently it had been only one

in ten. The total number of deaths among the 404 cases was 99. Other operations than ovariotomy had been done in the hospital; for example, amputation at the hip joint, removal of the lower jaw, and operations for vesico-vaginal fistulæ and ruptured perineum, and these showed that better results were obtained when the same care was bestowed upon them as upon the ovarian cases. The hospital was not perfect, but practically it afforded very good results. Mr. Wells then mentioned that he was now retiring from the active work of the hospital, having been elected consulting surgeon, and that this was probably the last operation he should perform there, unless he operated again next week. But it had been arranged that public consultations should be held at the hospital every Friday; due care being taken to respect the feelings of the patients.—*Lancet*, Dec. 15, 1877.

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Salicylic Acid.—M. Sée informs the correspondent of the *Brit. Med. Journ.* (Dec. 15, 1877), that his success with salicylic acid has been so unexpected and overwhelming in the cure of rheumatism and gout that he has been induced to try it in other analogous complaints, such as arthritis, produced by surgical or other causes, and the results have been identical with those effected in gout and rheumatism; viz., marked amelioration, if not complete cure, in two or three days. He is not prepared to explain the *modus operandi* of salicylic acid in these cases; but believes that, besides being an analgesic, it promotes the absorption, and prevents the reproduction, of morbid products, thus rendering *nil* one of the principal arguments brought against it by its detractors, that it would favour rather than prevent valvular disease of the heart and great vessels The detractors of the new remedy put forward as another argument against it the constant failure they have met with in their practice, to which M. Sée replies that it is not the medicine that is to blame, but the failures are owing most probably to the timidity with which certain practitioners have prescribed it; for, to be effective, it must be administered in sufficiently large doses: four to six *grammes* (sixty to ninety grains) a day of salicylic acid, or eight to ten *grammes* (one hundred and twenty to one hundred and fifty grains) of the salicylate of soda. He gives a decided preference to the latter, as being more soluble and more manageable, and prescribes it largely diluted in the proportion of one-tenth. Sometimes, however, severe gastric symptoms arise; but, in the great majority of cases, they may be put down to the impurity of the salt. Sometimes the salicylate produces other disagreeable symptoms, such as deafness, tinnitus aurium, and a peculiar cerebral disturbance; but these need not alarm the physician, as they soon vanish on a discontinuance of the medicine for a short time. Another accusation brought against it is its toxic action on the system even in moderate doses. Here M. Sée observes that, if pure, the salicylate of soda may be administered to the extent of twenty *grammes* (three hundred grains) a day, without fear of poisoning the patient, as the salt is so quickly eliminated, that it can have no time to accumulate in the system.

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Antiseptic Surgery.—In an interesting clinical lecture on the Treatment of Compound Fractures (*Med. Times and Gaz.*, Nov. 24, 1877), Prof. Richard Volkmann says that during the past four years and a half he has treated conservatively by the antiseptic method seventy-five cases of compound fracture of the extremities occurring in seventy-three patients. "A small proportion of these—eight altogether—had to be subjected to secondary amputation. But neither of those who were treated throughout on conservative principles, nor of those where the conservative treatment failed, and where secondary amputation had to be undertaken, did one single patient die; *they one and all recovered!*

"As I am not the inventor of the 'antiseptic method' of treating wounds—the greatest advance which surgery as a science has ever made—you will not consider it boasting if I venture to call this a very remarkable result; indeed, as compared with our former experience, it is quite an unheard-of result. For the mortality of

such injuries, until the antiseptic method was discovered, was a very high one, no matter what treatment was adopted."

And he again says, "But now, since the introduction of the antiseptic method of treating wounds, I get more successful cases in a single year than I had previously done during the whole of my surgical career."

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Iodoform in Fissure of Anus.—M. Tarnier recommends (*Union Med.*, Dec. 27) the spreading of a small quantity of the powder of iodoform over the surface of a cotton plug, and bringing this in direct contact with the fissure. Four or five dressings suffice in some cases to produce a cure.—*Med. Times and Gaz.*, Jan. 5, 1878.

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Relation between Urinary Secretion and Irritation of Spermatic Plexuses.—M. Nepveu read a paper at the Havre meeting of the French Association for the Advancement of Sciences, in which he gave the results of his continued researches on the variations which the urinary secretion may undergo as a consequence of various traumatisms. He has arrived at the conclusion that the testis may, in certain abnormal conditions (such, for example, as follow injections of iodine into the tunica vaginalis, and in neurosis of the testis), be the starting point of reflex actions affecting the urinary secretion. This reflex action, looked at especially as a result of injections of iodine into the tunica vaginalis for hydrocele, is exhibited by a series of oscillations in the secretion, the first effect being oliguria or deficient secretion, which lasts for some days, and is followed by polyuria, succeeded by a return to the normal condition. This result of the injection of iodized solutions into the tunica vaginalis may be regarded, M. Nepveu thinks, as an experiment which establishes the reality of a physiological connection bebetween the renal secretion and irritation affecting the spermatic plexuses.—*Lancet*, Oct. 6, 1877.

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Pneumonomycosis Sarcinica. — Under this name, M. Heimer describes in the *Deutsches Archiv für Klin. Med.*, vol. xix., a case of which the following is an abstract. A servant-man, aged 57, admitted into hospital with symptoms of an advanced stage of pulmonary phthisis, was seized on the eighth day with pneumonia of the right lung. The sputa contained fibrinous coagula, pus-cells, granular cells, epithelium, fat, numerous molecules, and a large number of sarcinæ. At the necropsy, there were found thickening, excavation, and caseation of both upper lobes; and the two lower lobes of the right lung were hepatized. In the anterior part of the middle lobe of the right lung was a cyst filled with gas and a little fluid. The gas had no bad smell, and the fluid had an acid reaction. The cavity was about four inches and three-quarters in circumference, and was bounded by the broken-down lung-tissue, which contained a large proportion of sarcinæ. The sarcinæ were colourless, and were found also in the pus-corpuscles. Two similar cases have been described by Virchow, and one by Cohnheim; all occurred in phthisical patients. Heimer believes that his patient took in the sarcinæ by inspiration while in hospital; that, through their very rapid development, they caused localized softening in the lung; and this gave rise to the fatal pneumonia.—*British Medical Journ.*, Nov. 24, 1877.

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Atmospheric Germs.—At the meeting of the Royal Society, on November 29th, a discussion took place on the subject of Professor Tyndall's well-known discoveries as to the influence of the invisible particles of the atmosphere, as exciters of putrefaction. Professor Tyndall has established by his experiments the following remarkable facts: 1. That the air is at all times, even when free from microscopically visible particles, beset with much smaller ultramicroscopical particles which communicate to it, when illuminated by the sunbeam or the beam of the electric light, a peculiar opalescence; 2. That this opalescence disappears when the air is allowed to remain absolutely tranquil; 3. That air which has undergone this change, *i. e.*, air from which the ultramicroscopical particles have sub-

sided, is no longer capable of contaminating liquids. From these facts, Dr. Tyndall concludes that the particles in question are organisms—the germs of septic bacteria. Dr. Burdon Sanderson, admitting the fact that the particles have the influence assigned to them, regards the evidence that they are organisms as insufficient; holding that, in respect of morphological entities, the only evidence that can be taken is that of observation. The present discussion has arisen out of a paper communicated to the Royal Society last summer, entitled, "Note on Dr. Burdon Sanderson's Latest Views of Ferments and Germs," in which Dr. Tyndall criticized certain parts of a lecture delivered in January last on *Contagium Vivum*. In this paper, after referring to certain writers who, he thinks, have wrongly invoked the microscope in deciding the question of ultimate structure, Dr. Tyndall proceeds: "It is not without concern that I see the habit of thought and expression against which I thus reasoned revived by so excellent a worker as Dr. Sanderson. My position is, and I think the uniformity of nature is on my side, that a particle, whether great or small, which, when sown, produces a plant, is proved thereby to be the germ of that plant; Dr. Sanderson's position is, that a particle, however fruitful it may be, ceases to be a germ, and dwindles to a molecular aggregrate when it becomes ultramicroscopical. It may be fairly asked, Have all microscopes, or only some, the right to define the germ-limit? Has a pocket-lens the right? If not, and assuredly it has not, what power of enlargement confers the right?" etc. In the introduction to his paper, Dr. Sanderson remarks that the difference between himself and Professor Tyndall appears to him to arise mainly from the difference of meaning attached to the words germ and structure.—*British Med. Journ.*, Dec. 8, 1877.

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Death from Chloroform.—A case of this which occurred at Ancaster, Ont., is reported in the *Canada Lancet* for Jan. 1878. Fatty degeneration of the heart was disclosed at the *post mortem*.

Handy Antidotes.—The French medical profession have frequently occupied themselves with the endeavour to add to their pharmacopœia an antidote which would answer the purpose in the majority of accidental poisonings, and which could always be kept at hand, so that it might be administered at once, before more special indications had the time to develop themselves, either according to information and anamnestics, which are often wanting in cases of accident, or, according to symptoms noted by observation of the patient. M. Mialhe has highly recommended, for this purpose, hydrated sulphate of iron mixed with calcined magnesia. This is a good antidote for the metallic salts, which it deoxidizes and changes into harmless sulphurets. But this antidote has the disadvantage of disengaging sulphydric acid in the presence of acids. It requires great nicety in preparation, and is difficult to keep. M. Dorvault has proposed, in cases of alkaloid, cyanic, and metallic poisonings, an antidote composed of equal parts of calcined magnesia, peroxide of iron, and washed powder of animal charcoal. This mixture also, however, changes if it be kept some time. M. Jeannel proposed to keep separately—1, a solution of sulphate of iron; and 2, a mixture of 80 *grammes* of calcined magnesia and 40 *grammes* of animal charcoal in 800 *grammes* of distilled water. This mixture, added at the moment of using to the solution No. 1, forms the antidote, which is to be administered in successive doses of from 50 to 100 *grammes* (about 1¾ to 3½ ounces). This antidote renders preparations of arsenic, zinc, and digitalis insoluble. It completely saturates free acid, and only acts partially on the alkaline hypochlorites and the oxide of copper. It also leaves in solution a small amount of morphia and strychnia, and the oxide of mercury in notable quantity. Professor Ranieri Bellini has made a communication to the Medico-Physical Society of Florence on the iodide of starch, which MM. Bouchardat and Quesneville were the first to introduce into therapeutics, and frequently employed in cases which required an active alterative medication, when the stomach refused to tole-

rate iodine in any other form. The iodide of starch is a chemical antidote which is specially appropriate to poisoning by sulphur, by the alkaline or earthy sulphurets, by caustic alkalies, ammonia, or any of the alkaloids. It is also an eliminating agent, very useful in the treatment of long-standing metallic poisonings, especially those resulting from lead or mercury. Dr. Bellini advises that the patient should always be made to vomit soon after the administration of the antidote, to rid him of the chemical products which result from the decomposition of the toxic agent, which in their turn might likewise become decomposed.—*British Med. Journal*, Dec. 22, 1877.

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Iodized Cod-Liver Oil.—Pale cod-liver oil (*Med. Times and Gaz.*, Dec. 15, 1877), one hundred grammes; iodoform, one-quarter of a gramme; oil of anise, ten drops. The iodoform removes from this oil its nauseous and disagreeable odour. M. Fonssagrives prescribes this mixture in the same manner as ordinary cod-liver oil, in cases in which it is desired to combine iodine with it.—*L'Union Médicale*, Dec. 6, 1877.

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Health of Grocers and Drapers.—The *Sanitary Record* says: "Recent statistics show that the rate of mortality among grocers is as 76 to 100 among the general population at equal ages, while the death-rate among drapers is as 108 to 100 by the same standard. On analyzing the cause of this difference between the drapers and the grocers, it is found that it lies in the mode of living. The principal disease which destroys the draper is pulmonary consumption. The explanation is simple: The grocer lives in a shop, the door of which is open the whole day, and he is very active himself in business; the draper, on the other hand, lives in a close place, with the doors of his shop closed, and in a dusty and close atmosphere. No one, whose pleasure or business calls on him to enter the majority of our large drapery emporiums in London, but will feel in a position to testify to the truth of this description. The heat and closeness which are their usual characteristics sufficiently account for the general pallor and unhealthy appearance of the male and female attendants in them."—*Med. Times and Gaz.*, Dec. 15, 1877.

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Poisonous Wall-papers.—A lecture on "Poisonous Wall-papers" was delivered a short time back before the Manchester Chemists and Druggists' Association by Mr. L. Siebold. The lecturer stated that out of sixty or seventy papers of various colours, blue, red, brown, pink, etc., analyzed by him, ten only were harmless, the rest containing arsenic. There is a popular impression that green papers only are to be feared; but the result of Mr. Siebold's examination should have the effect of rendering householders and heads of families suspicious of some of the most innocent-looking colours. It is reasonable to assume that to the presence of deleterious ingredients contained in certain wall-papers may be ascribed many little illnesses of children where no apparent cause exists for the same, and which sometimes puzzle the medical attendant. —*Lancet*, Dec. 29, 1877.

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Obituary Record.—At Bordeaux, in December last, aged 86 years, M. Elie Gintrac, formerly Professor in, and Director of the School of Medicine at Bordeaux.

M. Gintrac was the author of a number of papers on diseases of the chest, but his most important work is his *Theoretical and Clinical Course on Pathology and Medical Therapeutics*, of which eight volumes have been published. It is characterized by erudition, good sense, and great clinical wealth.

——— At Paris, on the 3d of December, aged 72, Jean-Bapt.-Philip. Barth, Commander of the Legion of Honour, late President of the Académie de Médecine, and Honourary Physician to the Hôtel Dieu.

M. Barth succumbed to an attack of pernicious fever contracted at Rome. *The Traité d'Auscultation*, which he wrote in conjunction with M. Henri Roger, was his principal work, and has achieved for him a well-deserved reputation.

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Its peculiar but happy arrangement makes it a very convenient book for reference. It appeals to all who desire to have a more familiar and correct acquaintance with drugs, not only as regards their influence upon disease, but also their action upon the human system in health. The editor has most certainly done his part well, and taken more care and done more work than is usual.—*Med. and Surg. Reporter*, Dec. 22, 1877.

The American editor has performed his labor of adapting the work to the requirements of our countrymen, in a most thorough and conscientious manner. In conclusion, we would commend the book to all who would have a short and concise manual of the present state of our knowledge of the physiological and therapeutical action of remedies.—*St. Louis Clin. Record*, Jan. 1878.

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This is a very valuable book, and is well adapted for a young practitioner. We have every reason to thank the author for a practical and suggestive work.—*London Lancet*, March 24, 1877.

He has succeeded in producing a volume that will be found an exceedingly useful companion to the standard works on practice. It abounds in information of value at the bedside, and is eminently practical throughout.—*N. Y. Med. Journ.*, April, 1877.

We heartily commend his book to the medical student as an honest and intelligent guide through the mazes of therapeutics, and assure the practitioner who has grown gray in the harness that he will derive pleasure and instruction from its perusal.—*Bost. Med. and Surg. Journ.*, March 8, 1877.

We could quote much that would interest our readers; but we desist, referring all to the volume itself as at once practical and scientific; as a treatise for the practitioner simply bent on learning the latest discoveries in therapeutics, and for the inquirer in search of the philosophy of medical practice.—*American Practitioner*, Sept. 1877.

HENRY C. LEA, PHILADELPHIA.